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ABSTRACT

This document consists of a combination of two separately published fact sheets, one on crisis nursery care for children at risk of abuse or neglect and one on respite care for families of children with disabilities or chronic illness. The fact sheet on crisis nursery care presents background information on the federal role in developing crisis nursery programs; a definition of crisis nursery care; and descriptions of a crisis nursery facility, a day care facility, a crisis shelter, multiple community sites, and in-home programs. Three references and names and addresses of two resource organizations are provided. The fact sheet on respite care begins with an outline of federal funding for respite care demonstration projects, and then offers a definition of respite care and descriptions of seven program models: in-home respite model, host family model, facility-based model, residential respite model, respite house model, parent cooperative model, and "respitality" model. The fact sheet concludes with three references and names of two resource centers. (JDD)

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General Information About

Crisis Nursery Care

Background

Crisis Nursery programs were first developed in the early 1970's to provide temporary child care (respite) for children at risk of abuse and neglect. Crisis nursery programs were also designed to offer an array of support services to the families and caregivers of these children. Recognizing the effectiveness of crisis nursery care and the need for additional programs, in 1986 Congress passed the *Temporary Child Care for Children with Disabilities and Crisis Nurseries Act* (as amended). This Act established federal funding for crisis nursery (and respite care) demonstration projects. Administered through the U.S. Department of Health and Human Services, Children's Bureau, competitive grants have been awarded to States since 1988 to assist private and public agencies in developing crisis nursery services across the United States.

Purpose

Crisis nursery programs provide a safe and supportive environment for children as well as a non-threatening, non-punitive resource for parents and caregivers.

What is Crisis Nursery Care?

The federal legislation defines crisis nursery care as temporary care for children who are at risk of abuse and neglect or who have experienced abuse or neglect. Most crisis nursery programs offer child care free of charge for a maximum of 30 days in any year. This care is usually available 24 hours a day. Most programs accept children at any time, day or night, in order to relieve a potential or existing emergency in the family.

Crisis nursery programs primarily serve children whose ages range from birth to twelve years. Often programs serve a particular age group (i.e. birth-three years or preschoolers, etc.).

Federally funded crisis nursery programs are required to provide referral to support services. However, most crisis nursery programs, regardless of their funding source, provide support services within their own service delivery system. Support services which may be provided by crisis nursery programs, or by an array of community agencies through informal or formal collaborative agreements, include:

- family counseling;
- individual counseling;
- service coordination (case management);
- parenting classes;
- access to medical services;
- home management training;
- employment training;
- help lines;
- substance abuse prevention counseling; and,
- developmental assessments.

Crisis Nursery Program Models

Crisis nursery program models for each local service area may differ according to the needs of the families within the community. For example, some crisis nursery programs may elect to serve families in situational emergencies such as families involved in divorce or a long hospital stay; whereas, other crisis nursery programs focus on serving children and families where potential abuse or neglect has been identified by the parents themselves or another agency.

Crisis nursery programs may provide both in-home or out-of-home care. Many crisis nursery programs utilize existing day care centers, private homes which have been licensed (similar to foster care homes) or emergency shelter facilities. Other programs are located in facilities which are specifically designated as a crisis nursery. The following descriptions are examples of local crisis nursery program models.

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Model 1: Center-based Model-Crisis Nursery Facility

Center-based crisis nursery care may occur in a licensed child care facility specifically designated as a crisis nursery. This model usually provides services 24 hours a day, 365 days a year. State requirements for food preparation, staff-child ratio, health and safety, and other licensing requirements must be followed. This model includes funding for professional and paraprofessional staff. This model may offer a variety of related programs such as substance abuse prevention programs and programs for special circumstances such as teenage mother assistance programs.

Model 2: Center-based Model-Day Care Facility

Many crisis nursery programs contract with existing day care centers which operate 24 hours a day. This cost effective model utilizes day care centers which already meet state licensing requirements and provide developmentally appropriate activities for the children. Day care staff members receive additional training on topics such as working with children at risk of abuse and neglect. Additional family support services are provided by the crisis nursery program director and community agencies as needed.

Model 3: Center-based Model-Crisis Shelters

This type of crisis nursery program is similar to the Day Care Facility Model since the crisis nursery administrative staff contracts with Crisis or Women Shelters to provide crisis nursery care for children and additional support services to parents. Families served in this type of program usually have an identified abuse or neglect situation.

Model 4: Community-Center Model-Multiple Sites

This type of crisis nursery model, frequently used in rural areas, provides temporary child care by utilizing a variety of existing community facilities (community centers, churches, etc.) in one or more geographical locations. These facilities are provided through informal or formal agreements. This model may not be able to offer temporary child care services 24 hours a day because of limited use of the community facility. Often, family support services such as parent support groups or parenting classes are offered for part of the time during which the child is receiving care. Trained volunteer families within the community can be the providers in this model. This model very effectively fosters interagency collaboration and coordination.

Model 5: Crisis Nursery In-Home Models

In-home crisis nursery programs provide some or all crisis nursery services within the family's home. Caring for the child within his or her home helps provide child care relief with minimal disruption of routine activities. Other in-home models provide temporary child care outside the home and parent support services within the home. These home-based services may include support counseling, activities to enhance parenting skills, or additional information according to individual family needs and assistance in accessing identified resources.

References

Beezley, Patricia and Mary McQuiston. *Crisis Nurseries: Practical Considerations.* National Center for the Prevention and Treatment of Child Abuse and Neglect, Department of Pediatrics, University of Colorado Medical Center, 1205 Oneida Street, Denver, CO, 80220; 1977.

The ARCH National Directory. ARCH National Resource Center, Coordinating Office, Chapel Hill Training-Outreach Project, 800 Eastowne Drive, Suite 105, Chapel Hill, NC, 27514; December 1991.

U.S. Senate, 102D Congress, 1st Session. S. 838, *Child Abuse, Domestic Violence, Adoption and Family Services Act of 1991.* Washington, Government Printing Office, 1991.

Resource Organizations

National Center on Child Abuse and Neglect, P.O. Box 1182, Washington, DC 20013, (202) 245-0586.

Clearinghouse on Child Abuse and Neglect and Family Violence Information, P.O. Box 1182, Washington, DC 20013, (703) 385-7565.

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ARCH Factsheet Number 2, January, 1992

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General Information About

Respite Care

Background

Respite Care programs emerged in the late 1960's as a result of the deinstitutionalization movement with the belief that the best place to care for a child with disabilities was in the child's home and community. Respite care became an essential component in the overall support services that families need to provide home care. Recognizing the effectiveness of respite care services, in 1986, Congress passed the *Temporary Child Care for Children with Disabilities and Crisis Nurseries Act* (as amended). This Act established federal funding for respite care demonstration projects. Administered through the U.S. Department of Health and Human Services, Children's Bureau, competitive grants have been awarded to States since 1988 to assist private and public agencies in developing model respite care services across the United States.

Purpose

Respite care programs provide temporary relief for families or caregivers. Additional family benefits include: allowing the family to engage in daily activities thus decreasing their feelings of isolation; providing the family with rest and relaxation; improving the family's ability to cope with daily responsibilities; maintaining the family's stability during crisis situations; helping preserve the family unit by lessening the pressures that might lead to divorce, institutionalization, neglect and/or child abuse; and, making it possible for individuals with disabilities to establish individual identities and enrich their own growth and development.

What is Respite Care?

The federal legislation defines respite care as in-home or out-of-home temporary, non-medical child care for families who have children with disabilities, chronic, or terminal illnesses. Most respite care programs offer services to families on a sliding fee scale with hourly and/or daily rates. Respite care services can range from a few hours of care up to three months of care depending on the needs of the families and the type of respite care program model available in a community. The ages served by respite programs range from infancy to adulthood. Often programs serve a particular disability or illness (e.g., children who have HIV-related conditions, children who are medically fragile, children with mental retardation).

Many respite care services are incorporated within larger social service agencies both at the community and /or state levels which provide an array of support services to families. Some of these support services can include: family counseling; family support groups; parent training; service coordination; assistive equipment services; and, access to medical services.

Respite Care Program Models

Respite care program models for each local service area may differ according to the needs of families/caregivers within the community. For example, some respite care programs may utilize an available bed in a health care facility or state institution for families who require extended respite options and whose child requires skilled care; whereas, other respite care programs may only offer time-limited (a few hours) services in the family's home. In addition, respite care services may be available to families through formal programs (i.e., trained staff) or may be available to families through informal networks (e.g., parent cooperatives, or cash subsidies from states to purchase respite through relatives and friends). The following descriptions are examples of local respite care program models.

Model 1: In-Home Respite Program Model

In-home respite programs offer services in the family's home for certain periods of time by trained, paid respite providers or volunteers. Respite programs train providers or volunteers in basic child care areas. Most respite programs interview families and providers and match the two in the provision of respite services; whereas, other respite programs act as "brokers" in which the families choose their own providers from a designated list. In-home respite services provide relief with minimal disruption of routine child care activities. State regulations regarding particular activities (e.g., administration of medications) are followed

by the respite program. In this type of model, families are usually charged on a sliding fee scale with the respite program paying the provider directly. In many states, families receive a cash subsidy or voucher to pay for in-home respite services.

Model 2: Out-of-Home: Host Family Model

Many respite programs offer services through a host family model in which respite care is provided in a surrogate family home similar to a foster care model. This model allows the child with disabilities to be cared for in a setting outside of his/her natural home. Host family models allow families to receive extended periods of respite. State regulations regarding fire and safety codes, licensing and other requirements must be followed. Most host families are trained by the respite program and paid a daily rate of care. Families are charged on a sliding fee scale for this service.

Model 3: Out-of-Home: Facility-based Model

This type of respite care program is similar to a Mother's Day Out program in which a particular facility (e.g., day care center, church, community center) offers respite on certain days at certain periods of time. This type of model allows families to take their children to a supervised environment. Facility-based respite models are staffed with trained respite providers, paraprofessionals, or volunteers who are able to care for children with certain disabilities. Families are charged for services based on a sliding fee scale. This model is very effective in rural areas.

Model 4: Out-of-Home: Residential Respite Model

In the residential respite model, respite services are provided in a residential or nursing center (e.g., group home, state institution, nursing home, hospital) within a community for individuals with disabilities or terminal illnesses who require skilled care services. Respite, in this model, is conducted by professional licensed personnel, usually for periods longer than 24 hours. Payment for respite services is usually a combination of family fees, state funding (i.e., Medicaid or waiver services), and/or private insurance.

Model 5: Out-of-Home: Respite House Model

In this type of model, a house, specifically designed for the provision of respite care, is available in the community with 24-hour care. Extended respite periods can occur up to 30 days. The respite house model is usually sponsored by a community or state agency and staffed with professional and paraprofessional staff. Families are charged daily rates based on a sliding fee scale. State requirements for food preparation, staff-child ratio, health and safety, and other licensing requirements must be followed.

Model 6: Parent Cooperative Model

Parent cooperatives have been developed in communities, especially rural areas, where respite services are very limited. In this type of model, families of children with disabilities and/or chronic illnesses develop an informal association and "trade" respite services with each other. This exchange program allows families to receive respite on scheduled dates. In most parent cooperatives, fees are not assessed. This model has proven to be effective for families whose children have similar disabilities. In this regard, families feel comfortable caring for someone else's child who has a disability or illness similar to their own child's.

Model 7: Respitality Model

Respitality is an innovative concept for providing respite care. It provides a cost-effective partnership between the private sector and respite care agencies. During Respitality, participating hotels provided the family with a room, a pleasant dining experience, and perhaps entertainment while a local respite program provides respite either in the family's home or in an out-of-home respite situation. The Respitality concept was developed by United Cerebral Palsy Associations, Inc., in 1985.

References

Cohen, S., & Warren, R.D. (1985). *Respite Care: Principles, Programs and Policies.* Austin, TX: Pro-Ed, Inc. (Available from Pro-Ed, Inc., 8700 Shoal Creek Blvd., Austin, TX 78758).

Salisbury, C.L., & Intagliata, J. (1986). *Respite Care: Support for Persons with Developmental Disabilities and Their Families.* Baltimore, MD: Paul H. Brookes Publishing Co. (Available form Paul H. Brookes Publishing Co., P.O. Box 10624, Baltimore, MD 21285-0624).

The ARCH National Directory. ARCH National Resource Center, Coordinating Office, Chapel Hill Training-Outreach Project, 800 Eastowne Drive, Suite 105, Chapel Hill, NC 27514; December, 1991.

Resource Centers

Texas Respite Resource Network (TRRN), Santa Rosa Children's Hospital, P.O. Box 7330, San Antonio, Texas 78207-3198; (512) 228-2794

National Information Center for Children and Youth with Handicaps (NICHCY), P.O. Box 1492, Washington, DC 20013: 1-800-999-5599

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